522-113 NSN 7540-00-634-4165

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Esophagogastroduodenoscopy (EGD) with possible biopsy

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be insertion of a flexible tube by mouth to examine the esophagus, stomach, and part of the small intestine (duodenum).
(Description of operation or procedure in layman's language)
Biopsy or removal of tissue samples may be performed if indicated. Possible complications/risks reviewed will include but not limited to medication reaction, intestinal perforation, bleeding, infection and death.

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: _____
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts of which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures as observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

_____
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor/Legal Guardian)*	*(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (Rev. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9-202-1

☆ **U.S. GOVERNMENT PRINTING OFFICE: 1995-390-857**

MEDDAC (Ft Meade) OP 412, 1 Mar 04
Esophagogastroduodenoscopy (EGD) with Possible Biopsy